Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS263S	A. BUILDING _____ B. WING _____	C 07/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON HEALTHCARE CENTER	1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments The Statement of Deficiencies was generated as a result of the complaint investigation survey conducted at your facility on July 17, 2008. The following complaint was investigated: CPT# 18651 - substantiated (Z 230) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiency was identified.	Z 000		
Z230	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439. This Regulation is not met as evidenced by: Based on interview, record review, and document review, the facility failed to ensure services were provided for adequate supervision to prevent elopement which resulted in the death of a resident (#1). Findings include: Resident #1 Resident #1 was a 67 year old male who was	Z230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS263S	A. BUILDING _____ B. WING _____	C 07/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON HEALTHCARE CENTER	1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z230	Continued From page 1 admitted to the facility on 5/19/08 and re-admitted on 6/24/08, with diagnoses including Cerebrovascular Accident, Dysphagia, Atrial Fibrillation, Coronary Artery Disease with Hyperlipidemia, Debility, Deconditioning, Encephalopathy, and Failure to Thrive. The resident eloped on 7/2/08 and was eventually found expired at the scene by the Henderson Police Department later in the evening. Record Review The facility's Elopement Risk Assessment dated 6/24/08, revealed the resident was "cognitively impaired with poor decision-making skills, had a pertinent diagnosis (Dementia), can ambulate, wanders, and was a new admission, not accepting his new situation." The second page of the assessment revealed the interventions that should or should not be implemented following the conclusion of the elopement assessment. The resident would require "frequent monitoring" and an "identification bracelet" to assist in preventing Resident #1 from eloping from the facility during his stay. The initial re-admission nursing assessment, dated 6/24/08, revealed Resident #1 was assessed as "very confused & speech unintelligible." The resident was also "very restless & agitated" and was unable to remain in bed. Nursing documentation indicated the following: - dated 6/25/08 at 8:00 AM, indicated the resident was wandering, which required a telephone call to the Physician Assistant. No evidence of	Z230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS263S	A. BUILDING _____ B. WING _____	C 07/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON HEALTHCARE CENTER	1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z230	Continued From page 2 additional orders for the resident was documented in the nurse's notes. - dated 7/1/08, revealed no indication that the resident was in distress or was exit seeking at the time of a transfer to the second floor (B2) room 2107B during the late evening (11:30 PM) of 7/1/08. - dated 7/2/08 at 0500 (5:00 AM), indicated Resident #1 was found heading down the 2300 hall stairs. The emergency alert did not sound off. The resident was assisted back to his room and a note was left for maintenance to fix the alarm. - dated 7/2/08 for 6:00 AM to 6:00 PM, indicated in the column titled, Evaluation/New Problem Assessment, "approximately 1700 (5:00 PM) CNA (certified nursing assistant) went to resident's room to get him for dinner and he was unable to be found." Further documentation in the evaluation column indicated following the facility staff's search for the resident in buildings B2 and B1, family members and Metro Police Department were notified. In the Assessment portion was noted that the resident's gait was "slow." He was disoriented and cooperative, with no other alerts that indicated the resident was at any risk for elopement. - On 7/2/08 at 1815 (6:15 PM) (entered as a late entry following the 1830 (6:30 PM) entry listed below), indicated at 1400 (2:00 PM) the resident again attempted to open the fire exit door at the end of the 2300 hall and caused the alarm to go off. It was further documented in the note that at 1630 (4:30 PM), a "code orange" (elopement code) was called and at 1720 (5:20 PM) the Henderson Police Department arrived to the facility, approximately 20 minutes after the initial call was placed. - On 7/2/08 at 1830, re-iterated the NAT (Nurse Aide in Training) went to the resident's room to get him for dinner and he was not in his room.	Z230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS263S	A. BUILDING _____ B. WING _____	C 07/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON HEALTHCARE CENTER	1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z230	Continued From page 3 Staff searched for the resident, and then family, doctor, and Metro Police were notified. Document Review The facility's Accountability Q (every) 1 Hour documents dated 7/2/08, indicated at 2:00 PM the resident was on the unit, however, there were no accountability checks at 3:00 PM and at 4:00 PM. The facility's testing documentation for exit door alarms revealed the 2100 unit exit stairwell door alarm failed twice on 7/4/08 at 7:30 AM and at 8:00 PM. The NAT indicated the exit door alarm in the 2100 hall failed to sound off when it was checked following her outside perimeter search for the resident. The door check occurred after 5:00 PM on 7/2/08. The Administrator acknowledged that the alarm was replaced due to a "possible short" on 7/4/08. The facility's final report following the investigation into the death of the resident revealed on 7/2/08 at 4:30 PM, "the CNA during her rounds was unable to locate the resident." This documentation supported the evidence that the the resident was not visually checked or observed for over 2 hours. Interview 1. On 7/17/08 at 1:15 PM, an interview conducted with the Administrator and Director of Nursing revealed the following: The Administrator indicated Resident #1 was beginning to become "clear" and a plan to discharge the resident "on that Friday" with his California family was being planned.	Z230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS263S	A. BUILDING _____ B. WING _____	C 07/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON HEALTHCARE CENTER	1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z230	Continued From page 4 The Administrator acknowledged that the resident made several attempts to leave the facility the day of the elopement. She indicated the resident was dressed in "nice street clothes" and it might have been difficult to distinguish the resident from one of the various visitors coming and going. The Director of Nursing indicated that while the facility engaged in their investigation, they learned that the resident was a "frequent flyer" during previous admissions at other medical facilities. She indicated her source of this information was from the resident's past medical records. The Director of Nursing confirmed the resident was found about 100 yards from the facility. She indicated the resident left the facility on the elevator to the B-building exit where the ambulance personnel entered the facility. The Administrator added that the exit stairwell door alarm on the 2100 unit had a "possible short" and it was replaced a couple days after the incident. The exit stairwell door was a few doors down the hall from the resident's room. The Director of Nursing confirmed a timeline by indicating that the nursing aide in training (NAT) was late to work, entered the unit at approximately 4:00 PM, began doing rounds and eventually made it to the resident's room about 4:30 PM. Once the NAT noticed that the resident was not on the unit, the NAT notified the LPN (licensed practical nurse) and eventually the charge nurse. Following the unsuccessful search, a "Code Orange" (elopement announcement) was called. On 7/17/08 at 2:35 PM, the NAT on duty at the	Z230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS263S	A. BUILDING _____ B. WING _____	C 07/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON HEALTHCARE CENTER	1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z230	Continued From page 5 time of the incident revealed the following: The facility was aware of the NAT reporting an hour or two late for her shift on 7/2/08. She indicated this was done by telephone the previous day (7/1/08). The NAT indicated she arrived at the facility between 3:45 PM and 4:00 PM, but indicated she didn't arrive at the nurse's station until 4:00 PM. Once at the nurse's station, the NAT received a brief report before beginning her rounds. At this time, the NAT mentioned that rounds were not completed on the 2100 unit prior to her arrival. The NAT indicated that someone should have been assigned to the unit until she arrived. The NAT arrived at the resident's room about "1/2 hour after starting rounds." She remembered it to be approximately 4:30 PM and at that time could not locate the resident. When she noticed that the resident was not in his room, the NAT notified the LPN, and then was directed to start a search of all the hallways, bedrooms and dayrooms on the second floor. Following the second floor search, the charge nurse directed the NAT to search the first floor and walk the outside perimeter of the facility. The NAT acknowledged that it wasn't until approximately 5:00 PM when she made her way outside to complete the perimeter walk with no success locating the resident. After the outside perimeter search, the NAT indicated she returned to her unit and the charge nurse directed her to check all exits. At this time, the NAT reported to the charge nurse that the exit stairwell alarm for the 2100 hallway did not sound off when checked.	Z230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS263S	A. BUILDING _____ B. WING _____	C 07/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON HEALTHCARE CENTER	1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z230	Continued From page 6 The NAT acknowledged that her participation in the search was over when officers from the Henderson Police Department arrived and instructed the NAT to attend to the residents on the 2100 hallway where she was assigned. 2. On 7/17/08 at 3:45 PM, a second interview with the Administrator and Director of Nursing, revealed the following: The Licensed Practical Nurse (LPN) on duty at the time of the incident, did not initiate rounds and visual observations of the residents between 2:00 PM and 4:00 PM on 7/2/08. Both Administrator and Director of Nursing acknowledged this was a problem and indicated the LPN was currently on a leave of absence. The Administrator and Director of Nursing acknowledged there was a big enough window of time when residents were not visually observed during rounds, and Resident #1 could have left the premises after 2:00 PM and prior to 4:00 PM or 4:30 PM on 7/2/08. The facility failed to ensure Resident #1 was safe between the hours of 2:00 PM and 4:30 PM on 7/2/08. After the resident was exit seeking on the 2300 unit stairwell and headed toward one of the facility's exits, the facility failed to ensure services provided to prevent Resident #1's elopement with resultant demise. Severity: 4 Scope:1 CPT #18651	Z230		